



1972 New Boston Road • Chittenango, NY 13037  
(315) 687-6727 • [ariseatthefarm.org](http://ariseatthefarm.org)

January 2026

Dear Families,

Thank you for participating in Horseback Riding, Ground Lessons, or Cart Driving at ARISE at the Farm! As a PATH Member Center, we are committed to providing children and adults of all abilities the opportunity to experience the benefits and joy of horsemanship.

**An updated Rider Application is required annually for all participants.** Signed and completed applications must be received **prior** to the first riding lesson. This includes the 2026 Rider Application (rider information, health history, personal information, and rider policies), Rider Lesson Availability, Policies, Liability and Photo Release, Authorization for Emergency Medical Treatment, Payment Form, and Physician Form. The applications should be mailed to **ARISE at Doc Marshall Farm, 1972 New Boston Road, Chittenango, NY 13037** or emailed to the attention of Laura Little [llittle@ariseinc.org](mailto:llittle@ariseinc.org).

Lessons for the 2026 season are: \$125 for a one-hour lesson.

**For new riders, when we receive your application, we will call you to schedule an orientation lesson.** This lesson will give us an opportunity to review the rider's goals and help us determine the best horse and tack. This will be a **half-hour un-mounted lesson at \$62.50**. Staff will meet the rider to assess needs. Riders will meet horses. Please bring your calendar to this lesson as we will be scheduling your future lessons at this time.

Returning riders need to send completed application but do not need orientation.

If the rider needs to take a break from lessons for medical reasons, a physician's release will be required prior to resuming lessons. We are committed to keeping the confidentiality of all client information. Please be assured that all data is held in strictest confidence.

Please call our office at **(315) 687-6727** if you have any questions.

Be sure to check our website for upcoming events!

Sincerely,

A handwritten signature in cursive script that reads "Laura Little". The signature is written in black ink on a light blue rectangular background.

Laura Little  
Farm  
Manager

Last Name: \_\_\_\_\_, First Name: \_\_\_\_\_



**2026 Participant Application**  
(This information must be updated annually)  
PLEASE PRINT LEGIBLY

PARTICIPANT NAME \_\_\_\_\_ DATE \_\_\_\_\_  
HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_ GENDER \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
EMAIL \_\_\_\_\_ HOME PHONE \_\_\_\_\_ CELL \_\_\_\_\_  
EMERGENCY CONTACT NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_  
EMPLOYER/SCHOOL \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_  
PARENT/LEGAL GUARDIAN \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_  
ADDRESS (if different from above) \_\_\_\_\_  
\_\_\_\_\_

**HEALTH HISTORY**

DISABILITY: PRIMARY \_\_\_\_\_ SECONDARY \_\_\_\_\_

**\*Riders with Down syndrome are required to have an annual medical clearance from a licensed physician that includes a neurological exam that specifically denies any symptoms consistent with atlantoaxial instability (AAI).**

Please indicate current or past ISSUES in the following areas:

	Y	N	Comments
VISION			
SENSATION			
COMMUNICATION			
HEART			
BREATHING			
DIGESTION			
ELIMINATION			
CIRCULATION			
EMOTIONAL			
BEHAVIORAL			
PAIN			
BONE/JOINT			
MUSCULAR			
THINKING/COGNITIVE			
ALLERGIES			
SEIZURES			
OTHER, please describe			

**PLEASE LIST ALL MEDICATIONS AND FOR WHAT PURPOSE**

MEDICATION	TAKEN FOR

Last Name: \_\_\_\_\_, First Name: \_\_\_\_\_



**2026 Participant Application**  
(This information must be updated annually)  
PLEASE PRINT LEGIBLY

**ARISE at the Farm has a weight limit. Applicants over the weight limit will be considered at our discretion.**

Functional	Status	Independent	Some Assistance	Dependent
Sitting				
Standing				
Walking				
Wheelchair				

Language: Verbal \_\_\_\_\_ Sign \_\_\_\_\_ Gestural \_\_\_\_\_ Augmentative \_\_\_\_\_

What do you hope you/your child will receive by participating in therapeutic horsemanship? \_\_\_\_\_

Please describe your/your child's strengths and abilities: \_\_\_\_\_

If there are any special issues (e.g. physical, behavioral, sensory, social) how do you prefer to handle typical situations? Please include methods of behavior modification, communication and anything else that may be pertinent for the instructors or volunteers to know while working with you/your child. \_\_\_\_\_

What is one goal related to activities of daily living? \_\_\_\_\_

**CONFIDENTIALITY AGREEMENT**

I agree to respect and observe privacy and confidentiality of the participants, volunteers, and personnel of ARISE at the Farm and not to discuss or disclose any sensitive information about any person or their family.

Rider's Name: \_\_\_\_\_ Date: \_\_\_\_\_

CLIENT, PARENT, GUARDIAN, CAREGIVER SIGNATURE \_\_\_\_\_

1972 New Boston Road, Chittenango, NY 13037 - (315) 687-6727

Last Name: \_\_\_\_\_, First Name: \_\_\_\_\_



## Payment Form

### Horseback Riding, Ground Lessons, & Cart Driving

☐ **Pay through Agency** (By checking this box, the information below must be completed in full or application will be returned.)

**★Please attach supporting documentation from the agency authorizing payment and quantity of lessons provided. If not attached the application will be returned to you.**

#### Primary Agency

Agency Name:		# of Lessons Provided:	
Care Coordinator:		Phone:	
Email:		Fax:	
CSS Broker (if applicable):		Phone:	
Email:		Fax:	
Signature:			

#### Secondary Agency

Agency Name:		# of Lessons Provided:	
Care Coordinator:		Phone:	
Email:		Fax:	
CSS Broker (if applicable):		Phone:	
Email:		Fax:	
Signature:			

#### Care Coordinator Information (if applicable):

Care Coordinator's Name: \_\_\_\_\_ Agency: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Do you utilize a Self-Direction budget? YES \_\_\_\_\_ No \_\_\_\_\_** If yes, please provide the following information:

Broker's Name: \_\_\_\_\_ Agency: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

☐ **Self-pay**

Contact:	Phone:	
Billing Address:		
City:	State:	Zip:
Signature:		

1972 New Boston Road, Chittenango, NY 13037 - (315) 687-6727

Last Name: \_\_\_\_\_, First Name: \_\_\_\_\_



## Policies

### Horseback Riding, Ground Lessons, & Cart Driving

**Payment Policy:** **ALL BOOKED LESSONS NEED TO BE PAID IN ADVANCE OR DAY OF LESSON.**

When applicable: In the event, that we are unable to collect from your designated agency, you are personally responsible for the remaining balance. Initial

**Self- Pay/Agency Pay** – In the event funding by either method changes, ARISE at the FARM must be notified immediately by the rider/parent/guardian. Initial

**Payment is required for any late cancellations/late cancellations due to illness/no shows.** Initial

**Cancellation Policy:** All lessons require 48 hr. notice for cancellations via text to 315-430-6957. Cancellations under 48 hrs., no shows, or failure to notify the Farm will incur the cost of the lesson, regardless of reason. Initial

After two no-show lessons without notice, a rider's spot will be reassigned to another rider. Initial

Late fees must be paid in full before scheduling future lessons. Initial

**Helmet Policy:** When near/on horses, riders must wear STM-SEI-approved riding helmets. Helmets are available for use at ARISE at the Farm. The instructor will fit the rider with the proper helmet. However, riders are encouraged to purchase their own helmets. Bike and ski helmets are not acceptable. Initial

**Clothing Requirements:** Riders should wear jeans or stretch pants. Smooth bottomed boots with a heel are recommended. Initial

If accompanied by staff, staff MUST wear closed-toe shoes. Initial

**Weather:** In the event of weather unsafe for riding, unmounted lessons will be held as scheduled. Staff reserves the right to cancel or reschedule lessons if weather conditions are deemed unsafe for riders, horses, or staff. Initial

**Siblings:** If siblings are in attendance with parents and/or caregivers during the rider's class, parents are responsible for the direct supervision of these children at all times. Noises and lots of activity can distract horses and other students. Initial

**Weight Limit:** ARISE at Doc Marshall Farm has a weight limit for mounted activities. Applicants over the weight limit will be considered at our discretion. Initial

**Safety:** ARISE at the Farm reserves the right at any time to refuse any rider we cannot safely accommodate.

By signing below, you are acknowledging that you have read and understand all of our policies and procedures here at ARISE at the Farm. Initial

Rider Name:

Signature:  
(Rider, parent, or legal guardian)

Date:

Last Name: \_\_\_\_\_, First Name: \_\_\_\_\_



Please indicate on the chart below all, of the times the rider would be available for lessons.

	Mon.	Tue.	Wed.	Thurs.	Fri.	Sat.
<b>Morning</b> 9:00 AM  to 1:00 PM						<b>Limited Saturday Sessions</b>
<b>Mid-Day</b> 1:00 PM  to 4:00 PM						<b>Limited Saturday Sessions</b>
<b>Evening</b> 4:00 PM to 5:30 PM					<b>No Lessons</b>	<b>No Lessons</b>

**Rider applications must be received prior to scheduling**

**Limited lessons during summer programs.**

Last Name: \_\_\_\_\_, First Name: \_\_\_\_\_



**Liability Release:** I would like to participate in the ARISE at the Farm program. I acknowledge the risks and potential risks that I/my son/my daughter/client is taking but feel that the potential benefits outweigh the risks assumed. I hereby, intending to be legally committed for myself, my heirs, and assignees, executors, and administrators, waive and release forever all claims for damages against ARISE, Inc., ARISE at the Farm, its Board of Directors, volunteers, and employees for any, and all injuries and/or losses that I/my son/my daughter/client may sustain while a rider in the ARISE at the Farm program. To my knowledge there is no reason why I/this person cannot participate in supervised equestrian activities.

Rider Name:

Signature:  
(Rider, parent,  
or legal guardian)

Date:

**Photo Release:** I authorize ARISE at the Farm, ARISE, and ARISE Foundation the use and reproduction of any, and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other uses for the benefit of the program.

☐ I Consent      ☐ I Do Not Consent

Rider Name:

Signature:  
(Rider, parent,  
or legal guardian)

Date:





## Horseback Riding, Ground Lessons, & Cart Driving

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or, while being on the property of the agency, I authorize ARISE at the Farm to:

1. Secure and retain medical treatment and transportation if needed.
2. Release rider records upon request to the authorized individual or agency involved in the medical treatment.

Rider Name:	Phone:
Address:	

In the event I cannot be reached:

Contact #1:	Phone:
Relationship:	

Contact #2:	Phone:
Relationship:	

Physician's Name:	Phone:
Preferred Medical Facility:	
Health Insurance Company:	Policy #:

### Consent Plan:

☐ **I Consent**      ☐ **I Do Not Consent**

This authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person below is unable to be reached.

Print Name:	Phone:
Signature:	Date:
Address:	
Relationship:	



Last Name: \_\_\_\_\_, First Name: \_\_\_\_\_



## Participant's Medical Clearance and Physician Statement

**TO BE COMPLETED AND SIGNED  
BY THE PARTICIPANT'S  
PHYSICIAN**



Participant: \_\_\_\_\_ DOB: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Past/Prospective Surgeries: \_\_\_\_\_

Medications: \_\_\_\_\_

Seizure Type: \_\_\_\_\_ Controlled: Y N Date of last Seizure: \_\_\_\_\_

Shunt Present: Y N Date of last revision: \_\_\_\_\_

Special precautions/needs: \_\_\_\_\_

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices: \_\_\_\_\_

For those with Down syndrome: Result of Neurological exam of Atlantoaxial Instability: \_\_\_\_\_ Present \_\_\_\_\_ Absent

**Please indicate current or past special needs in the following system/areas, including surgeries:**

System/Areas	Y	N	List Any Surgeries
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Accredited Center will weigh the medical information above against the existing precautions and contraindications.

Physician Name: \_\_\_\_\_ MD DO NP PA Other \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ License/UPIN number: \_\_\_\_\_

Last Name: \_\_\_\_\_, First Name: \_\_\_\_\_

Rider's Name: \_\_\_\_\_ Date: \_\_\_\_\_

### Rider's Goals and Objectives

Please mark the boxes below which are individual goals for this rider. These goals will be used by our instructors to develop lesson plan objectives.

Physical Goals	Social & Recreational Goals	Cognitive & Educational Goals
<input type="checkbox"/> Improved balance	<input type="checkbox"/> Socialization	<input type="checkbox"/> Color recognition
<input type="checkbox"/> Improved posture	<input type="checkbox"/> Cooperation	<input type="checkbox"/> Shape recognition
<input type="checkbox"/> General coordination	<input type="checkbox"/> Sportsmanship	<input type="checkbox"/> Verbalization
<input type="checkbox"/> Eye/hand coordination	<input type="checkbox"/> Enjoyment	<input type="checkbox"/> Vocabulary expansion
<input type="checkbox"/> Head control	<input type="checkbox"/> Confidence/self-esteem	<input type="checkbox"/> Sequencing
<input type="checkbox"/> Trunk control	<input type="checkbox"/> Communication skills	<input type="checkbox"/> Spatial awareness
<input type="checkbox"/> Muscular strength	<input type="checkbox"/> Increased attention	<input type="checkbox"/> Reading skills (Letter recognition, Word recognition, Basic sentences, Other)
<input type="checkbox"/> Gross motor skills	<input type="checkbox"/> Decreased attention	<input type="checkbox"/> Math skills (Number recognition, Add/Subtract, Multiplication, Fractions, Measurements, Other)
<input type="checkbox"/> Fine motor skills	<input type="checkbox"/> Responsibility	<input type="checkbox"/> Other:
<input type="checkbox"/> Decreased tactile defensiveness	<input type="checkbox"/> Self-sufficiency	
<input type="checkbox"/> Muscle tone	<input type="checkbox"/> Social skill development	
<input type="checkbox"/> Increased range of motion	<input type="checkbox"/> Teamwork	
<input type="checkbox"/> Sensory Integration	<input type="checkbox"/> Respect	
<input type="checkbox"/> Endurance	<input type="checkbox"/> Independence	
<input type="checkbox"/> Visual/Spatial orientation	<input type="checkbox"/> Trust	
<input type="checkbox"/> Other:	<input type="checkbox"/> Interpersonal relationships	
	<input type="checkbox"/> Other:	

Is there anything else the riding center should know to make the riding session safe and productive?

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This form was completed by: \_\_\_\_\_ Relationship: \_\_\_\_\_

#### For Center Use Only

Helmet Size: \_\_\_\_\_ Horse Needs: \_\_\_\_\_  
Equipment Needs: \_\_\_\_\_  
Volunteer Needs: \_\_\_\_\_  
Environment Needs (Group, Private, Semi-Private Lesson etc.): \_\_\_\_\_  
Other: \_\_\_\_\_  
  
Signed by: \_\_\_\_\_ Date: \_\_\_\_\_

Questions? Please contact Laura Little at (315) 687-6727 or [llittle@ariseinc.org](mailto:llittle@ariseinc.org)